Report to the
Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol

Plan to Coordinate
Substance Abuse Intervention and Treatment Programs and Services

This report was supported in part by the Substance Abuse Prevention and Treatment Block Grant administered through the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services,
and by National Highway Traffic Safety Administration funds administered through the
Virginia Department of Motor Vehicles

Executive Summary
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Substance Abuse Services Council
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October 2005

Executive Summary

In response to a charge from the Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol convened in 2002, the Substance Abuse Services Council has prepared the following plan, focused on the requirements set forth in Recommendation 25 of the *Report and Recommendations to the Governor from the Governor's Task Force to Combat Driving Under the Influence of Drugs and Alcohol*, issued July 2003. Recommendation 25 assigned five tasks to the Council, all related to the provision of prevention, intervention and treatment services provided to Repeat and Hardcore Drunk Drivers served by local Virginia Alcohol Safety Action Programs, which receive oversight from the Commission on Virginia Alcohol Safety Action Programs, a legislative body:

- Establish statewide goals and priorities for substance abuse interventions and treatment efforts, placing a high priority on hard core drunk drivers and repeat offenders;
- Identify and promote a standardized assessment tool, such as the Addiction Severity Index (ASI) or Substance Abuse Subtle Screening Inventory (SASSI), that can be used by all service providers to help match individuals to appropriate intervention and treatment programs;
- Establish uniform, statewide substance abuse standards and treatment definitions for use by service providers to improve understanding and implementation of treatment programs and evaluations of effectiveness;
- Identify programs and approaches that have documented success;
- Collect and track data collected from administration of standardized assessment to identify characteristics of at-risk population in order to enhance the design of effective prevention, intervention and treatment programs.

This plan provides information about the work of the Council to address these assignments, as accomplished by the Program Committee of the Council, as well as other as yet to be appointed work groups that will operate within the authority of the Council. The plan identifies four goals: (1) reinforcing the use of the Simple Screening Instrument as the standard approach to screening offenders by all local safety action programs by providing training; (2) identifying an assessment instrument appropriate for Repeat Offenders and Hardcore Drunk Drivers and recommending that its use be incorporated into service agreements between local safety action programs and local treatment

providers; (3) developing and adopting common definitions of types of treatment and standards for treatment services for uniform application by all VASAP service providers; (4) develop recommendations for data collection to assist in identifying persons likely to become Repeat Offenders and Hardcore Drunk Drivers. The first goal has already been accomplished and progress on goals 2 and 3 are well underway. In addition, the Council addressed several Recommendations listed under Item 32 of the report related to use of third-party reimbursement for BAC blood tests, recordkeeping and developing a dedicated funding stream that would address costs related to DUI enforcement and treatment.

Activities in 2005 and 2006 will be supported by National Highway Transportation Safety Action funds granted by the Department of Motor Vehicles to the Department of Mental Health, Mental Retardation and Substance Abuse Services on behalf of the Substance Abuse Services Council.

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Background

On October 4, 2002, at the direction of Governor Warner, Secretary of Public Safety John W. Marshall and Secretary of Transportation Whittington W. Clement convened the Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol with the specific goal of reducing offenses by those who have been previously convicted of driving or boating under the influence (DUI or BUI, respectively). In the context of public safety, these persons are referred to as "*hardcore drunk drivers*" and are defined as "*those who drive with a high blood alcohol concentration of 0.15 or above, who do so repeatedly, as demonstrated by having more than one drunk driving arrest, and who are highly resistant to changing their behavior despite previous sanctions, treatment or education efforts.*"[1] The Task Force, which included members from all three branches of government, was divided into three working committees: General Deterrence; Specific Deterrence; and Prevention, Intervention, and Treatment. The tasks for the General Deterrence Committee focused on improving public awareness about the dangers of and penalties for driving and boating under the influence of alcohol and other drugs. The Specific Deterrence Committee focused its work on policy recommendations concerning individual behaviors, including procedural changes to make existing laws more effective and legislation to increase penalties for DUI and BUI. The focus of the Prevention, Intervention, and Treatment Committee was to help those individuals whose DUI or BUI behaviors are not changed by either legal or educational strategies, recognizing that these individuals are either members of at-risk populations or have already developed significant problems with alcohol or other drugs.

To inform its work, the Prevention, Intervention, and Treatment Committee learned about the programs and practices of local Virginia Alcohol Safety Action Programs (VASAP), current treatment approaches for individuals participating in VASAP, the continuum of publicly funded treatment available in Virginia for substance use disorders, and the gap between the number of people in need of treatment and the existing capacity. The Commission on Virginia Alcohol Safety Action Programs (VASAP) is a legislative commission comprised of members of the General Assembly, judges, representatives of local alcohol safety action programs, the Department of Motor Vehicles, and the Department of Mental Health, Mental Retardation and Substance Abuse Services. The Commission also appoints an advisory board that includes representatives of local safety action programs, the state or local boards of mental health, mental retardation and substance abuse services, and other community mental health organizations. The

[1] The Century Council. From the Grassroots to a National Agenda. Community Forums Report: Issues and Insights on Hardcore Drunk Driving. p. 2. No date given.

Commission is supported by an administrative staff, and provides oversight to local ASAP programs, each of which is responsible to its own policy board. [*Code of Virginia* § 18.2-271 *et seq*]. Local courts refer offenders to local safety action programs, where they are screened using the Simple Screening Instrument (SSI), a standardized instrument developed by the Center for Substance Abuse Treatment (CSAT) at the federal Substance Abuse and Mental Health Services Administration to screen for alcohol and other drug abuse in at-risk populations.[2] Figure 1 displays these relationships.

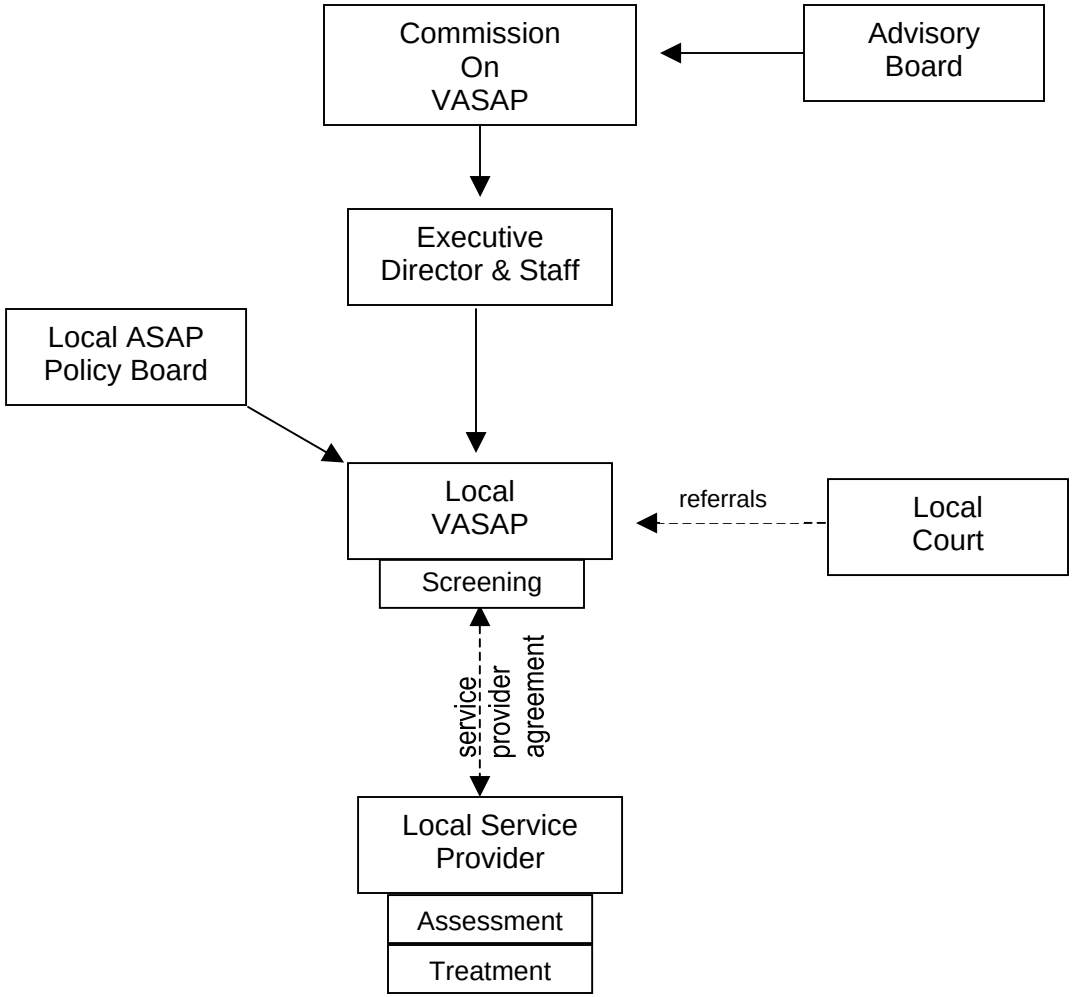
One of the key issues the Committee identified was the inconsistent range of treatment services available from community to community. One of the effects of this variability was that assessment practices varied from community to community, so that a common assessment tool and communication about the results of the assessment are not standard. Another effect is that a complete array of services is not available in every community. As Repeat Offenders and Hardcore Drunk Drivers are likely to need intense services, such as residential treatment or outpatient treatment that occurs several times a week for several hours each session, this lack of access seriously affects the outcome of the treatment experience. The jurisdiction in which the person is arrested defines how he is assessed and what treatment he is offered. Furthermore, although the local safety action programs are certified to meet standards established by the Commission, there is no guarantee that the clinical treatment services to which clients are referred by local safety action programs are provided by a professional specifically knowledgeable about the treatment of substance abuse or dependence. This is especially critical for Repeat Offenders and Hardcore Drunk Drivers as their clinical needs are often more complex, frequently involving abuse of or dependence on multiple substances, as well as problems with mental illness. In summary, systematic assessment procedures and standards for acceptable treatment practices based on the assessment are not in place. If the offender has a dependency on alcohol or other drugs, and the treatment is not effective, then the offender is likely to reoffend.

To address these issues, members of the Prevention, Intervention, and Treatment Committee provided several recommendations to the Task Force that were subsequently adopted, two of which were specifically assigned to the Substance Abuse Services Council in the Report and Recommendations of the Task Force issued July 2003. The following report concerns the Council's progress addressing Recommendation 25, stated below. The report on Recommendation 26 is due 2008, and will be presented at the appropriate time.

[2]Winters, KC and Zenilman, JM. Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases. Treatment Improvement Protocol 11. 1994. U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. DHHS Publication No. (SMA) 94-2094.

Figure 1: State and Local Reporting and Referral Relationships

Key:
Reporting: _____
Referral: ----------



Recommendation 25:
The Substance Abuse Services Council, in partnership with the Virginia Alcohol Safety Action Program, the Department of Mental Health, Mental Retardation and Substance Abuse Services, and other partners, should develop a plan that coordinates substance abuse intervention and treatment programs and services, no later than 2005. Nominal administrative costs are anticipated.

In particular, this plan should address and recommend ways to:

- Establish statewide goals and priorities for substance abuse interventions and treatment efforts, placing a high priority on hard core drunk drivers and repeat offenders;
- Identify and promote a standardized assessment tool, such as the Addiction Severity Index (ASI) or Substance Abuse Subtle Screening Inventory (SASSI), that can be used by all service providers to help match individuals to appropriate intervention and treatment programs;
- Establish uniform, statewide substance abuse standards and treatment definitions for use by service providers to improve understanding and implementation of treatment programs and evaluations of effectiveness;
- Identify programs and approaches that have documented success;
- Collect and track data collected from administration of standardized assessment to identify characteristics of at-risk population in order to enhance the design of effective prevention, intervention and treatment programs.

Plan
The Program Committee of the Substance Abuse Services Council (SASC), chaired by Rudi Schuster, representing the Department of Criminal Justice Services (DCJS), a member agency, consisted of representatives from the Commission on Virginia Alcohol Safety Action Programs (VASAP) and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), both member agencies, as well as representatives from local VASAP programs, and the Mid-Atlantic Addiction Technology Transfer Center (Mid-ATTC) at Virginia Commonwealth University. The Program Committee met several times to develop the following plan to address the requirements of the Task Force. A copy of Program Committee membership is included as Appendix B of this report. This plan includes certain goals, objectives and action steps to coordinate VASAP substance abuse intervention with treatment programs. In addition, working on behalf of the Council, DMHMRSAS applied for and secured a grant from the Department of Motor Vehicles (DMV) using National Highway Safety Action Funds to support the costs incurred in developing and implementing the plan. DMHMRSAS has recently learned the DMV has awarded a second year of funding for this project.

Priority Consideration: Screening, intervention, referral, assessment, and treatment services for Repeat Offenders and Hardcore Drunk Drivers.

Issue 1: Reinforce the use of the Simple Screening Instrument. Screening and assessment are separate activities with separate goals. Screening indicates whether or not the individual has a significant substance abuse problem, and screening results provide the local VASAP with information to determine whether or not the person would benefit

from education or would require treatment to address the substance abuse behavior that preceded the arrest. Screening activities generally require limited training or time to administer or score.

Assessment instruments provide detailed information about the nature, duration and severity of the substance abuse problem and usually require some sophistication to administer and score. In addition, sound assessments are crucial to designing or matching treatment services to the individual needs of the DUI/BUI offender, including ancillary issues that may affect the offender's capacity to remain drug or alcohol free, such as attitudes towards authority, mood disorders, or social supports. Assessment instruments are also important in measuring outcome, as they can provide measures for baseline behavior and behavior after participation in treatment. In the VASAP system, assessments are conducted by contract treatment providers, not by the VASAP case managers. However, understanding the measures utilized by specific assessment instruments provides the case manager with context about the treatment in which the offender participates and helps the case manager assure that the offender is receiving the appropriate intensity and duration of treatment.

Goal 1.0: Reinforce the use of the Simple Screening Instrument, and identify and promote a limited selection of assessment instruments to be used by all service providers to help match individual service needs to treatment programs.

Objective 1.1: Provide training to local ASAP case managers in the Simple Screening Instrument to reinforce its use as the standardized screening instrument.

Progress: VASAP case managers participated in one-day review training on the Simple Screening Inventory at the 2005 Virginia Summer Institute for Addiction Studies. They also received overview information about the Addiction Severity Index (ASI) as many community services boards that provide treatment services on contract to local VASAPs utilize this assessment instrument. The grant from the Department of Motor Vehicles (National Highway Transportation Safety Administration funds) supported scholarships to the entire weeklong institute for case managers from each of the 24 local VASAP programs.

Objective 1.2: After a standard assessment instrument has been identified, staff will explore methods of training that will be helpful to treatment staff from around the state to develop the skills to use the standard assessment instrument.

Plan: Using grant funds from the Department of Motor Vehicles (National Highway Transportation Safety Administration funds) the Department of Mental Health, Mental Retardation and Substance Abuse Services will contract with the Mid-Atlantic Addiction Technology Center (Mid-ATTC) to identify assessment instruments most suitable for assessing the Repeat Offender and Hardcore Drunk Driver population and for administration in treatment environments that vary significantly in infrastructure. Mid-ATTC will produce a report that will include, at a minimum, the following information: the clinical utility for diagnosis, treatment placement, treatment planning, treatment outcome; the types of

measures reported; the amount, intensity and estimated cost of training required to administer and interpret the results of the assessment; the cost of the instrument (if proprietary); the accuracy (validity, reliability, cultural, language or gender issues, cut-off scores); complexity of and time required to administer, score and interpret; and the suitability of the instrument for the general service delivery system utilized by local VASAPs. The report will also recommend a limited number of assessment instruments and provide rationale for selection using the information specified above. The Substance Abuse Services Council will make a recommendation to the Commission and Mid-ATTC will provide training about the instrument to local VASAP case managers to assist them in using the information produced by the assessment to incorporate into service agreements with local treatment providers, and to assist them in monitoring services to assure that offenders referred for treatment receive services that are appropriate in intensity and duration. This may include training to provide familiarity with patient placement criteria of the type developed by the American Society of Addiction Medicine.

Issue 2: Uniform, statewide treatment definitions and standards are needed to provide a shared understanding about the continuum and quality of treatment necessary to improve treatment outcomes for DUI/BUI offenders. Standards, in the nature of clinical benchmarks, should be based on evidence or consensus based practices, and should be incorporated in treatment programs modeled after those that have proven successful for this population.

Goal 2.0: Develop, disseminate and adopt uniform definitions and standards for treatment of DUI/BUI offenders.

Objective 2.1: Establish uniform treatment definitions for use by service providers to improve understanding and implementation of treatment programs and evaluations of effectiveness.

Progress: The Substance Abuse Services Council recommends that service definitions adapted from Taxonomy 6 of the Department of Mental Health, Mental Retardation and Substance Abuse Services be utilized. Many VASAPs do contract with local community services boards, which already use this taxonomy. In addition, the taxonomy offers a broad array of services and defines services by intensity and duration, two key issues in the successful treatment of substance use disorders. A copy of the adapted taxonomy is attached as Appendix A.

Plan: These definitions will be distributed to VASAP staff via upcoming training planned regarding evidence and consensus based practices (See Objective 2.2). They will also be utilized in the development of standards and service agreements between local VASAPs and local service providers.

Objective 2.2: Establish uniform, statewide standards for substance abuse treatment for service providers to improve implementation of treatment programs and evaluations of effectiveness.

Plan: The Chair of the Substance Abuse Services Council will establish a work group with the assigned task of developing recommendations for clinical quality benchmarks for use in VASAP contracting and monitoring of treatment services. These benchmarks will be based on evidence and consensus-based practices, and will address outcome measures identified in the Council's report on outcomes as required in §2.2-2691 of the *Code of Virginia*. The work group will also identify programs that have proven to be effective with the Repeat Offender and Hardcore Drunk Driver. The work group will include representatives from state agencies currently providing treatment services (DMHMRSAS, DOC, DJJ) and a representative from VASAP. The work group will report its recommendations by 2007. The Mid-ATTC will provide training "on line" to VASAP case managers to assist them in determining which programs are evidence or consensus based, as well as training specifically pertaining to evidence and consensus based treatment practices for Repeat Offenders and Hardcore Drunk Drivers at the 2006 Virginia Summer Institute for Addiction Studies. In addition, Mid-ATTC will provide training to VASAP providers. The cost will be addressed by the DMV-NHTSA grant to DMHMRSAS.

Issue 3: There is presently no mechanism established to identify characteristics of populations at risk of becoming Repeat Offenders or Hardcore Drunk Drivers so that programs providing prevention, intervention and treatment for this population can be targeted. This information could be used to inform service design regarding age, gender and other characteristics to improve effectiveness and to assist in identification for earlier intervention.

Goal 3.0: Develop recommendations for data collection that will assist in identifying the characteristics of Repeat Offenders or Hardcore Drunk Drivers so that prevention and intervention programs can be developed that target these individuals to prevent repeat offenses and high blood alcohol concentration levels while driving or boating.

Objective 3.1: Collaborate with other state agencies, to include the Department of Motor Vehicles and the Department of Mental Health, Mental Retardation and Substance Abuse Services, to collect data by augmenting existing data collection and analysis initiatives that will provide information about the demographic and clinical characteristics of Repeat Offenders and Hardcore Drunk Drivers.

Plan: The Commission on VASAP will collaborate with the Department of Motor Vehicles in the design of its database to incorporate data collection and analysis on individual DUI/BUI offenders, tracking those with BAC at arrest of 0.15 or higher, or those arrested more than twice in a five year period. (Please refer to the study on DUI-related record keeping, below.) The Commission on VASAP will examine its own data for characteristics of recidivists, as well. This information will be reviewed by a workgroup established by the Chair of the Substance Abuse Services Council, to include representatives from the Commission on VASAP, the Department of Motor Vehicles, and the Department of Mental Health, Mental Retardation and Substance Abuse Services. The workgroup will be charged with identifying predictive characteristics of Repeat

Offenders and Hardcore Drunk Drivers and recommending evidence or consensus based early interventions that might deter re-offending or blood alcohol concentrations of 0.15 or higher. The workgroup will also use this information to make recommendations concerning improvement of programs and services to reduce the frequency of Repeat Offenders and Hardcore Drunk Drivers. The work group will report its recommendations by 2007.

Other Comments on Further Studies in the Report to the Governor's Task Force to Combat Driving under the Influence of Drugs and Alcohol

Item 32 of the report recommends that the Secretary of Transportation request the Virginia Transportation Research Council conduct several studies that are of interest to the Substance Abuse Services Council, as follows:

A study on the collection, use and feasibility of third-party reimbursement for blood tests for BAC level for drivers admitted to hospitals, no later than 2005.

Currently many hospitals are not collecting this information because, if the person does have alcohol in his system, the third-party payer may elect to deny payment for immediately subsequent health care. The lack of this information makes it difficult for the health care provider to provide adequate emergency care or to intervene in the affected driver's substance abuse issue. In addition, the lack of data collection concerning this issue relegates its significance to an anecdotal level. National data indicate that many health care costs are strongly related to abuse of alcohol, but state level data are impossible to obtain on a consistent basis because BAC levels are not routinely collected upon admission to the Emergency Room.

A study and recommended methods for creating a standardized system for DUI-related record keeping across state agencies that would coordinate and integrate databases and make information more readily available, no later than 2005.

The Council should receive information about the results of this study to possibly utilize for Objective 3.1.

A study to determine the feasibility and impact of creating a dedicated funding stream (supported through fines and user fees), to support local DUI enforcement programs, public education campaigns and substance abuse prevention, intervention and treatment services, no later than 2008.

Virtually all prevention activities in the Commonwealth are currently supported by either federal or local funds. The Commonwealth is fortunate, however, to host significant knowledge at a variety of state agencies, represented on the Council, related to prevention and early intervention. In addition, funding to support treatment services is stagnant. As costs rise, this has had the impact of reducing treatment capacity. Treatment services that will be effective with Repeat Offenders and Hardcore Drunk Drivers are likely to be intense and have an extended duration. Professionals trained in evidence must deliver these services and consensus based clinical practice in safe and accessible settings.

Infrastructure for housing and evaluation is expensive. The Council respectfully requests that it have an opportunity for input into the design and implementation of this study.

Appendix A
Abbreviated Taxonomy for Providers of Substance Abuse Treatment Services to Virginia Alcohol Safety Action Programs

INPATIENT SERVICES include:

- hospital-based 24 hour detoxification
- other hospital-based 24 hour substance treatment
- use of medication under the supervision of medical personnel in local hospitals or other 24 hour per day care facilities to systematically eliminate or reduce the effects of alcohol or other drugs in the body.

OUTPATIENT SERVICES include:

- outpatient counseling with individuals, groups and families
- opioid detoxification and maintenance services
- case management
- intensive outpatient (services provided multiple times per week for less than six hours per day, less than five days per week)

DAY SUPPORT SERVICES include:

- day treatment (coordinated, comprehensive, multi-disciplinary treatment for at least six hours per day, at least three to five days per week)

RESIDENTIAL SERVICES include

- highly intensive residential services for individuals with co-occurring mental health and substance abuse services
- intensive residential services that include
  - detoxification in a nonhospital, community-based setting (less than 30 days for intensive stabilization, daily group therapy, individual and family therapy, case management, and discharge planning)
  - intermediate rehabilitation (up to 90 days for supportive group therapy, individual and family therapy, case management, community preparation)
  - therapeutic community (90 or more days in a highly structured environment whre residents, under staff supervision, are responsible for daily facility operations; services include intensive daily group and individual therapy, family therapy, development of daily living skills and readiness for or engagement in community employment)
  - halfway houses (90 days or more for 24 hour supervision, training in daily living functions such as meal preparation, personal hygiene, laundry, budgeting, transportation)
- jail-based habilitation services (at least 90 days)
  - highly structured environment where residents, under staff supervision, are responsible for the daily operations of the program;
  - services include intensive daily group and individual therapy, family therapy, development of daily living skills and readiness for employment, and discharge planning (daily living skills in conjunction with the therapeutic milieu structure);
  - inmates participating in the are usually housed separately from the general population

- supervised residential services include supervised apartments that are directly operated or contracted programs that place and provide services to individuals, with an expected length of stay exceeding 30 days, and includes

  - subsidized as well as non-subsidized apartments;
  - staff support and supervision
  - usually provided in conjunction with outpatient services.

Appendix B
Program Committee

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